STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/28/24 through 05/01/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # EJ4J11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/28/24 through 05/01/24. Event ID# EJ4J11. The following intakes were investigated NC00215501, NC00215175, and NC00213897. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		5/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain shared resident bathrooms in good repair (Rooms #112 and #114) and maintain clean resident bathrooms (Rooms #308 and #310) for 2 of 12 shared resident bathrooms reviewed for environment. The findings included: a. Observation of the shared resident bathroom for Rooms #112 and #114 on 4/29/24 9:08 AM revealed the wall around the plumbing behind the toilet had missing drywall. A black, brown, and green substance was observed to surround the missing drywall around the plumbing to the toilet. The baseboard behind the toilet was observed to be pulled back from the wall and exposed missing drywall.	F 584	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. • Room # 112- and # 114-bathroom wall around the plumbing need drywall was repaired on 05/15/2024. • Room #308 and # 310 bathroom around toilet was cleaned and base area was recalked on 05/17/2024. • The bathroom on the #112 and # 114 room was deep cleaned on 05/17/2024 removing dark matter from the wall.and areas that were baseboard had gaps were repaired in #112 and # 114 bathroom. • Room Audit has been completed to have drywall and baseboard repaired and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 On 5/01/24 at 1:03 PM an observation of the shared resident bathroom for Rooms #112 and #114 revealed the wall around the plumbing behind the toilet had missing drywall. A black, brown, and green substance was observed to surround the missing drywall around the plumbing to the toilet. The baseboard behind the toilet was observed to be pulled back from the wall and exposed missing drywall. b. Observation of the shared resident bathroom for Rooms #308 and #310 on 4/28/24 at 12:03 PM revealed the toilet to have a brown, black substance around the caulking of the base of the toilet. On 5/01/24 at 1:09 PM an observation of shared resident bathroom for Rooms #308 and #310 revealed the toilet to have a brown, black substance around the caulking of the base of the toilet. The substance was able to be removed with light friction. A continuous observation and interview were conducted on 5/1/24 from 1:18pm through 1:21 PM with the Maintenance Manager, Housekeeping Manager, and Administrator for shared resident bathrooms for Rooms #112 and #114 and Rooms #308 and #310. The Maintenance Manager stated he was unaware of missing drywall and a substance around the plumbing in shared bathroom for resident Rooms #112 and #114. He further revealed he was not aware the baseboard was not affixed to the wall. He stated it appeared as though there was moisture that was causing what looked like it could be mold. The Maintenance Manager stated	F 584	plumbing have been repaired. How the facility will identify other residents having the potential to be affected by the same deficient practice. • In-service was done By Staff Development Coordinator on 05/16/2024 to discuss with the Interdisciplinary team the importance of identifying and reporting rooms that need repair such as holes in the wall, and cove base repair, housekeeping staff was in-serviced by housekeeping director on reporting repairs that are needed to Administrator/Designee. • Room Audit of all rooms was completed on 5/16/2024 for cleanliness and repairs by Administrator/designee. • Drywall and baseboard repaired, and plumbing was completed on 05/16/2024 by maintenance Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • Monitoring rooms for cleanliness/repairs as needed by housekeeping director/ Designee. • Administrator/Designee will audit rooms/bathrooms 5 times a week for 4 weeks; 3 times week for 4 weeks; and weekly for 4 weeks. • This will be reviewed in the Quality Assurance Performance Improvement meeting by the Administrator and the (IDT) monthly for 3 months to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 he should have been notified about these issues. He indicated he conducted monthly maintenance rounds of the facility. Regarding shared bathroom for resident Rooms #308 and #310, the Housekeeping Manager stated the substance around the caulking of the base of the toilet could have been due to a buildup of excess water when the bathroom floors were mopped. She further stated that housekeeping staff should scrape around caulked areas to remove the built-up substance. The Maintenance Manager added that the toilet in shared resident bathroom for resident Rooms #308 and #310 needed re-caulking. In an interview with the Administrator on 5/01/24 at 1:29 PM she revealed staff should notify the Maintenance Manager of any maintenance concerns regarding shared bathroom for resident Rooms #308 and #310. She further revealed housekeeping staff were to ensure resident bathrooms remain clean.	F 584	Corrective Action for those having the potential to be affected. • An audit of rooms on will be completed by the housekeeping supervisor/ assign Designee to ensure cleaning of the rooms. Any alterations identified will be corrected/modified as appropriate. • Systematic Changes: The Administrator/assign Designee provided education to staff on accuracy of reporting repairs when needed. • Monitoring: The Administrator/Designee will audit rooms weekly for one month then bimonthly for two months to ensure compliance with resident's homelike environment. • Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. • The Administrator/assign Designee will implement the plan of correction and ensure any additional recommendations are carried out.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to accurately code the current tobacco use status on	F 641	How corrective action will be accomplished for those residents found to have been affected by the deficient	5/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 a Minimum Data Set (MDS) Assessment for 1 of 1 resident (Resident #50) reviewed for smoking. The findings included: Resident #50 was admitted to the facility on 6/13/23. Review of the Admission Minimum Data Set (MDS) Assessment dated 6/20/23 revealed Resident #50 was cognitively intact and coded "No" for current tobacco use. On 4/28/24 at 3:05 pm Resident #50 was observed smoking a cigarette unsupervised in the designated smoking area. An interview with Resident #50 on 4/30/24 at 12:01 pm revealed he kept on his person his smoking supplies which included his cigarettes and a lighter. The resident further indicated he had been a smoker for over 40 years. During an interview with the MDS Coordinator on 4/30/24 at 3:12 pm she stated Resident #50 was a smoker and smoking had not been coded correctly on his MDS assessment. An interview with the MDS Corporate Consultant on 4/30/24 at 3:25 pm revealed the procedure was for the MDS Coordinator to review physician's orders, receive information from the morning meetings and interview residents to make sure the information entered on the MDS was accurate. The Director of Nursing was interviewed on 4/30/24 at 3:05 pm. She indicated the floor nurses assessed residents for smoking when	F 641	practice. " The facility failed to accurately code an Admission Minimum Data Set for resident# 50. " The facility modified resident #50 care plan to reflect current tobacco use on assessment on 04/29/2024. How the facility will identify other residents having the potential to be affected by the same deficient practice " Effective 04/29/2024 Minimum Data Set Nurses reviewed 30 days discharge assessments on residents to ensure accuracy of coding tobacco use. No additional concerns identified. " Effective 04/29/2024 Minimum Data Set Nurses reviewed current resident assessments to ensure accuracy of coding. No additional concerns identified. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " Administrator/ Designee will audit 5 discharge assessments weekly to ensure discharge assessments are coded accurately. " Administrator/designee will audit 5 admission assessments weekly to ensure assessment for height are coded accurately. " Results of these audits will be reviewed monthly in Quality Assurance Meeting for further problem resolution if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 they were admitted. The MDS assessment should have been correctly coded at the time of admission. During an interview with the Administrator on 5/1/24 at 9:24 am she indicated the MDS should have reflected Resident #50's smoking status.	F 641	needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Corrective Action for those having the potential to be affected: " An audit of all current residents with tobacco was completed by the MDS/ assign Designee to ensure accurate MDS coding. Any alterations identified will be corrected/modified as appropriate. " Systematic Changes: The Administrator/assign Designee provided education to MDS staff on accuracy of coding MDS and review of current assessment/care plans. " Monitoring: The corporate MDS consultant will audit new MDS's weekly for one month then bimonthly for two months to ensure compliance with resident's coding accurately. " Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. " The Administrator/assign Designee will implement the plan of correction and ensure any additional recommendations are carried out.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		5/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6	F 656		

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to develop a comprehensive person-centered care plan for a resident that smoked for 1 of 1 resident (Resident #50) reviewed for supervision to prevent accidents. The findings included: Resident #50 was admitted to the facility on 6/13/23. Review of the Admission Minimum Data Set (MDS) Assessment dated 6/20/23 revealed Resident #50 was cognitively intact and coded for no tobacco use. Review of Resident #50's comprehensive care plan dated 6/20/23 and last updated 9/20/23 revealed he was not care planned for smoking. Nursing progress notes dated 8/15/23, 9/21/23, and 9/26/23 indicated Resident #50 was a current smoker. Observation of Resident #50 on 4/28/24 at 3:05 pm in the smoking area of the facility, revealed he was smoking unsupervised. Interview with Resident #50 on 4/30/24 at 12:01 pm revealed he kept his smoking supplies to include his cigarettes and a lighter on his person. The resident further indicated he had been a smoker for over 40 years and smoked half a pack a day. During an interview with the MDS Coordinator on	F 656	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1. Corrective action accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #50 has been reviewed and updated and a new smoking screen completed by Administrator on 04/28/2024. How the facility will identify other residents having the potential to be affected by the same deficient practice • A review has been completed on 8 of 8 current like residents to ensure care plans have been updated and smoking screens are in place by the MDS/Designee on 05/13/2024. • 8 of 8 care plans were in place. • All smoking screens were updated by MDS/Designee 05/13/2024 to validate appropriate care plans. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Director of Nursing/Designee will audit all smoking assessments to ensure appropriate care plan in place. • This audit will be completed 5xper week for 4 weeks than 3xper week for 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 4/30/24 at 3:12 pm she stated she completed the care plans and all residents who were smokers should have had a care plan to include interventions. Resident #50 should have had a care plan to include smoking interventions. An interview with the MDS Corporate Consultant on 4/30/24 at 3:25 pm stated a care plan should have been completed to reflect a resident who was a current smoker. Resident #50 should have had a care plan for smoking. An interview with the Administrator on 5/1/24 at 9:24 am revealed nursing should have reassessed Resident #50 as soon as they realized he was smoking, and a care plan completed to reflect his smoking status.	F 656	• The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. Corrective Action for those having the potential to be affected: • The Licensed Nursing staff will be educated by DON/Designee on the process of completing a Smoking Assessment on new admissions and as needed with change of condition. • The DON/Designee will also educate Licensed Staff on completing an appropriate care plan. • This education will be provided by the Staff Development Coordinator/ Designee and completed by 05/31/2024 for Licensed staff including contract staff. Licensed staff not educated by 05/31/2024 will receive education prior to working on the floor.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		5/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 Based on observation, record review, resident and staff interviews, the facility failed to assess a resident's ability to smoke independently and retain smoking materials for 1 of 1 resident reviewed for smoking. (Resident #50) The findings included: Resident #50 was admitted to the facility on 6/13/23 with diagnoses which included unspecified dementia, with other behavioral disturbance. Review of the admission Minimum Data Set (MDS) Assessment dated 6/20/23 revealed Resident #50 was cognitively intact and coded for no tobacco use. Review of Resident #50's comprehensive care plan dated 6/20/23 and last updated 9/20/23 revealed he was not care planned for smoking. A review of the medical record revealed no smoking assessment completed for Resident #50. A nursing progress note written by the Administrator dated 8/15/23 indicated Resident #50 was alert and oriented to person, place, and time. Resident #50 was able self-propel from one unit to another and was a current smoker. Review of nursing progress note written by the Assistant Director of Nursing (ADON) dated 9/21/23 indicated Resident #50 was alert and oriented and continued to smoke. The nursing progress note written by the Assistant Director of Nursing (ADON) dated	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. • Resident admitted and resided within facility. Will have a smoking assessment done on admission/quarterly. • The facility modified resident #50 care plan/smoking assessment to reflect current tobacco use on smoking assessment on 04/29/2024. How the facility will identify other residents having the potential to be affected by the same deficient practice. • Any resident admitted and had a history of smoking use has the potential to be affected by the alleged deficient practice. • An audit was completed on 04/30/2024 all residents with tobacco use coding in the last 14 days were assessed for complete investigation and care plans were updated as needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? • An audit was completed on 04/30/2024 all residents with tobacco use coding in the last 14 days were assessed for complete investigation and care plans were updated as needed. • Nursing staff was reeducated/in-service on 05/13/2024 on implementing smoking assessments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 9/26/23 indicated Resident #50 was alert and oriented. He was a current smoker who smoked in the designated smoking area independently. Observation of Resident #50 on 4/28/24 at 3:05 pm in the smoking area of the facility, revealed he was smoking unsupervised. Interview with Resident #50 on 4/30/24 at 12:01 pm revealed he kept his smoking supplies to include his cigarettes and a lighter on his person. The resident further indicated he had been a smoker for over 40 years and smoked half a pack of cigarettes a day. The Director of Nursing (DON) was interviewed on 4/30/24 at 3:05 pm. She indicated the floor nurse would assess residents for smoking upon admission. The Assistant Director of Nursing (ADON) was interviewed on 5/1/24 at 12:28 pm. She revealed Resident #50 was a current smoker. She further stated that she had encouraged Resident #50 to inform the staff when he was going to smoke. An interview with the Administrator on 5/1/24 at 9:24 am revealed she was aware Resident #50 was a smoker. She further revealed the floor nurse was responsible for completing smoking assessments upon admission to the facility. She indicated she did not know Resident #50 was smoking upon admission and that could have been a reason his smoking assessment was missed. Nursing should have reassessed Resident #50 as soon as they realized he was smoking. Resident #50 did not have a smoking assessment and one should have been completed as he was a smoking resident.	F 689	• DON/designee will begin audits 05/13/2024 starting with 5 residents weekly and monthly x 3months to ensure appropriate smoking assessments. • Monitoring: The corporate MDS consultant will audit new MDS's weekly for one month then bimonthly for two months to ensure compliance with resident's coding accurately. • The Executive Director /designee will be responsible for compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. • The results of these audits will be reviewed by Administrator/Designee in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achieved x4 consecutive weeks. • The QA Committee will identify any trends or patterns. • make recommendations to revise the plan of correction as indicated. Corrective Action for those having the potential to be affected: • An audit of all current residents with tobacco was completed on 05/16/2024 by the MDS/ assign Designee to ensure accurate MDS coding. Any alterations identified will be corrected/modified as appropriate. • Systematic Changes: The Administrator/assign Designee provided education to MDS staff on accuracy of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689	coding MDS and review of current assessment/care plans. • Monitoring: The corporate MDS consultant will audit new MDS's weekly for one month then bimonthly for two months to ensure compliance with resident's coding accurately. • Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. • The Administrator/assign Designee will implement the plan of correction and ensure any additional recommendations are carried out.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews, the facility failed to administer oxygen (O2) in accordance with the physician's order and they failed to have cautionary signage for O2 use for 1 of 1 resident (Resident #35) reviewed for respiratory care. The findings included:	F 695	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. • On 04/30/2024, the DON notified the Medical Director of the oxygen concentrator machine not been at correct level on Resident # 35, and the incorrect	6/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 12 1a. Resident #35 was admitted to the facility on 5/15/23 with diagnoses that included chronic respiratory failure. A review of the quarterly Minimum Data Set (MDS) dated 2/22/24 indicated Resident #35 was severely cognitively impaired. She had received oxygen therapy and tracheostomy (trach) care during the MDS assessment period. Resident #35's care plan dated revealed 4/26/24 revealed the resident had a tracheostomy related to impaired breathing mechanics. The goals revealed the resident would have clear and equal breath sounds in both lungs and that the resident would be monitored for breath sounds each shift. The intervention stated the oxygen would be delivered by a trach mask at 6 liters per minute (lpm). A review of Resident #35's physician order dated 5/15/23 revealed an order for oxygen delivered via trach collar at 6 lpm indefinitely. An observation of Resident #35 was conducted on 4/28/24 at 12:17 PM. Resident #35 was lying in bed wearing a trach collar with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. Another observation of Resident # 35 conducted on 4/29/24 at 8:44 AM revealed Resident #35 was lying in bed wearing a trach cannula with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. An additional observation of Resident #35 conducted on 4/30/24 at 8:32 AM revealed Resident #35 was lying in bed wearing a trach	F 695	dosage of oxygen was corrected at once by the Director of Nursing. The Director of Nursing then obtained the O2 stats on resident #35 to assure no harms was done. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice • The DON and/or designee perform a review of all medical records on 04/30/2024 for all residents that have oxygen orders and ensure EMAR reflect the resident's oxygen status. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? • DON or designee will educate all licensed nurses on policy and procedures for Oxygen use and following physician orders, and ensuring that the care plan reflects residents' status, starting 04/30/2024 and completed by 05/20/2024. • All staff not in-serviced by 05/20/2024 will be required to complete the in-service prior to working. • The DON/or designee audit on 04/30/2024 all current residents to ensure that all residents that require oxygen have current doses in place on the concentrator. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 13 cannula with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. An interview conducted with Nurse #3 on 4/30/24 at 9:48 AM. She stated Resident #35 had an order for 6 lpm continuous oxygen. Nurse #3 stated she had not assessed the resident yet that morning and was not aware her oxygen was set at 4.5 lpm. An interview was conducted with the Director of Nursing (DON) on 5/1/24 at 09:54 AM. She stated staff were to follow the doctor's orders for oxygen administration. A telephone interview of Nurse #1 conducted on 5/1/24 at 1:05 PM revealed the oxygen orders for each resident were found in the electronic chart. Nurse #1 stated she checked the oxygen concentrator for Resident #35 every shift to make sure it was on the correct setting. She stated she did not check the chart orders every shift and further stated the O2 orders for Resident #35 were supposed to be set at 6 lpm. She stated she did not note the oxygen had been incorrect on the shifts she worked 4/28/24 and 4/29/24. Nurse #2 could not be reached by telephone for an interview during survey. A telephone interview was conducted with the physician on 5/1/24 at 1:48 PM. He stated staff were to follow his orders as written. The Administrator on 5/1/24 at 1:46 PM. She revealed staff should be checking the residents' orders each shift. She further revealed staff should follow the doctor's orders.	F 695	• The DON or designee will review all new orders and admissions 5 times weekly for three months in the morning clinical meeting, to ensure that residents requiring oxygen have current orders in place, and care plan reflects status for oxygen use. • Need to review all new orders in the clinical morning meeting as well in case a resident gets an order added for oxygen. • All findings will be brought to the Quality Assurance Performance Improvement Committee monthly for ongoing compliance. Corrective Action for those having the potential to be affected: • Systematic Changes: The Administrator/assign Designee provided education to staff on administering oxygen. • The DON or designee will review all new orders and new admissions 5 times weekly for three months in the morning clinical meeting, to ensure that residents requiring oxygen have current orders in place, and care plan reflects residents' status for oxygen use. • Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. • The Administrator/assign Designee will implement the plan of correction and ensure any additional recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 14 1b. An observation of Resident #35 was conducted on 4/28/24 at 12:17 PM. There was no cautionary or safety signage for the use of oxygen observed in Resident #35's room, outside her room, or anywhere in her environment. Observation of Resident #35 conducted on 4/29/24 at 8:44 AM revealed there was no cautionary signage in Resident #35's room, outside her room, or anywhere in her environment. An additional observation of Resident #35 conducted on 4/30/24 at 8:32 AM revealed there was no cautionary signage in Resident #35's room, outside her room, or anywhere in her environment. An interview with Nurse #3 was conducted on 4/30/24 at 9:48 AM. Nurse #3 stated there should have been oxygen in use signage on Resident #35's door. An interview and observation conducted with the Director of Nursing (DON) and Administrator on 5/1/24 at 9:54 AM revealed oxygen in use signage should be on Resident #35's door. The Administrator stated the oxygen signage had been placed on the incorrect resident's door.	F 695	are carried out.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		5/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to remove expired medications from the refrigerator for 2 of 2 med rooms. Findings included: 1a. An observation on 05/01/24 at 1:31 PM in the presence of the Director of Nursing (DON) revealed the medication room #1 (100 hall) refrigerator had 5 expired antibiotics. There were 2 expired Intravenous (IV) antibiotic infusion doses for a resident who was no longer in the facility with the expiration date of 4/8/24. An additional 3 expired IV antibiotic infusion doses were found for another resident with an expiration date of 4/19/24.	F 761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. • The facility plan is that all medications and biologicals are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents or visitors. • All required medications and biological will have an opened date or expiration date label on the medication and that all discontinued or expired medications will be removed from use from the medication cart or refrigerator. • The process failure occurred when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16 1b. Per the manufacturer's recommendation for Purified Protein Derivative (PPD) storage, PPD vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. An observation on 05/01/24 at 1:52 PM in the presence of the DON revealed the medication room #2 (300 hall) refrigerator had 2 multidose vials of Tuberculin Purified Protein Derivative (PPD for Tuberculosis skin test) found opened and not dated. An interview conducted with the DON on 05/01/24 at 1:57 PM revealed the facility pharmacy technician comes every month to inspect/review medications stored at the facility. She stated they have a new pharmacy technician. The DON stated the nursing staff are supposed to date any medication once opened and remove any expired medications. On 05/01/24 at 3:02 PM an interview with the administrator was conducted. She stated as soon as medication is no longer used or needed it must be removed from facility storage. She added that all opened medications must be dated once opened before it is stored.	F 761	staff members failed to return to pharmacy, expired medication opened leaving the vial without an expiration date. How the facility will identify other residents having the potential to be affected by the same deficient practice. • On 05/01/2024 staff were re-educated by the Director of Nursing on Medication Administration in the facility which included expired medications. • An Inservice on 05/01/2024 on expired medications including disposing of all expired medications was completed by the Director of Nursing. • Medication rooms 100 hall was audit by DON/designees on 05/01/2024 for expired or unused medication. • Medication rooms 300 hall was audit by DON/designees on 05/01/2024 for expired or unused medication. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. • The Charge Nurse will audit medication storage room for discontinued and expired medications three (3) times a week for twelve (12) weeks for any opened, undated medications and expired medications. • The Charge nurse will remove all medications from medication carts and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 17	F 761	return to pharmacy three (3) times a week. • The Executive Director /designee will be responsible for compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. • The Director of Nursing will review expired medications audits completed by the unit managers every week and follow-up on any trends or patterns. • The Director of Nursing will report results to the QAPI committee monthly. • The QAPI committee will determine the need for further monitoring after the initial twelve weeks. Corrective Action for those having the potential to be affected: • Systematic Changes: The Administrator/assign Designee provided education to staff on labeling of Drugs/Biologicals. • Monitoring: The DON/Designee will audit med rooms weekly for one month then bimonthly for two months to ensure compliance with labeling of Drugs/Biologicals. • Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18	F 761	• The Administrator/assign Designee will implement the plan of correction and ensure any additional recommendations are carried out.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		6/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 19 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure medical records were complete and accurate for 1 of 1 resident reviewed for respiratory services (Resident #35).	F 842	How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 20 The findings included: Resident #35 was admitted to the facility on 5/15/23 with a diagnosis of chronic respiratory failure. A review of Resident #35's Minimum Data Set (MDS) dated 2/22/24 revealed she was severely cognitively impaired. She had received oxygen therapy and tracheostomy care during the MDS assessment period. A review of the physician's order dated 5/15/23 revealed Resident #35 was to receive oxygen by tracheostomy (trach) collar at 6 liters per minute (lpm) indefinitely. An observation of Resident #35 was conducted on 4/28/24 at 12:17 PM. Resident #35 was lying in bed wearing a trach collar with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. Another observation of Resident # 35 conducted on 4/29/24 at 8:44 AM revealed Resident #35 was lying in bed wearing a trach cannula with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. Review of Resident #35's Medication Administration Record (MAR) for April 2024 revealed Nurse #1 (AM shift) and Nurse #2 (PM shift) had documented with electronic initials that Resident #35 was receiving oxygen at 6 lpm by trach collar on 4/28/24. Further Review of the April 2024 MAR revealed Nurse #1 and Nurse #2 had again documented with electronic initials that Resident #35 was receiving oxygen at 6 lpm by	F 842	• On 04/30/2024 Resident #35 attending physician was notified that facility staff failed to document that Resident #35 correct oxygen levels on medical record. • Resident #35 O2 stats were obtained by DON once error was noted. • A Ex order form will be created which will require the signature of accepting nurse that concentrator/medical records match. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential to be affected by the alleged deficient practice. On 04/30/2024, the Director of Nursing began a 100% match back review which included going through each medical record in the facility and ensuring that each oxygen order in the medical records matched the orders on the Medication Administration Record. This review was completed by reviewing 100% of current resident's orders to ensure residents received the correct oxygen level. DON corrected all concentrator that were inaccurate. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? • Licensed Staff, including FT, PT, PRN, and all new hires were educated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 21 trach collar on 4/29/24. A telephone interview of Nurse #1 conducted on 5/1/24 at 1:05 PM revealed the oxygen orders for each resident were found in the electronic chart. Nurse #1 stated she checked the oxygen concentrator for Resident #35 every shift to make sure it was on the correct setting. She stated she did not check the chart orders every shift and further stated the oxygen orders for Resident #35 were supposed to be set at 6 lpm. She stated she did not note the oxygen had been incorrect on the shifts she worked 4/28/24 and 4/29/24. Nurse #2 could not be reached by telephone for an interview during survey. The Director of Nursing (DON) interview was conducted on 5/1/24 at 09:54 AM. She stated staff should document correct oxygen assessments. The Administrator was interviewed on 5/1/24 at 1:46 PM. She stated staff should document correct oxygen assessments.	F 842	the DON/Designee regarding maintaining an accurate medical record, to include only signing off the Oxygen Record for items that were completed by the licensed nurse responsible. • An audit was completed by the DON/Designee on all residents with current orders for Oxygen to ensure that they are being recorded correcting per order and that documentation was accurate. Audit was completed on 04/30/2024. Any discrepancies were corrected immediately. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • Unit Managers will audit treatment administration records (EMARs) for the application of oxygen orders 5x week for 4 weeks, then weekly thereafter to ensure that the written orders are carried out as ordered and that the documentation on the MAR is accurate. • All findings will be brought to the Quality Assurance and Performance Improvement Committee monthly with the QAPI committee responsible for ongoing compliance. Corrective Action for those having the potential to be affected: • Systematic Changes: The Administrator/assign Designee provided	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 22	F 842	education to staff on signing off orders. • Monitoring: The DON/Designee will audit orders weekly x5 for 4 weeks then weekly to ensure compliance with written orders. • Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. • The Administrator/assign Designee will implement the plan of correction and ensure any additional recommendations are carried out.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		5/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 23	F 867		

will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 24 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 25 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 10/6/21 recertification survey and the 1/20/23 recertification and complaint investigation survey. This was for 3 recited deficiencies on the current recertification and complaint survey of 5/1/24 in the areas of accuracy of assessment (F641), development/implement comprehensive care plan (F656), and label/store drugs and biologicals (F761). The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F 641 Based on observation, record review, resident and staff interviews, the facility failed to accurately code the current tobacco use status on a Minimum Data Set (MDS) Assessment for 1 of 1 resident (Resident #50) reviewed for smoking.	F 867	• The position of Brookstone living Center regarding the process that led to this deficiency was failure to follow established facility policy related to quality assurance (QAPI). • The procedure for implementing the acceptable plan of correction for the specific deficiency cited. • By 05/22/2024, the facility quality assurance (QA) Committee held two meetings to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) committee and review on-going compliance issues. The director of nursing (DON), minimum data set (MDS) nurse, dietary manager, maintenance director, medical records, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 04/21/2024/2023 the DON provided updates regarding POC to the Medical Director. • On 05/02/2024, the corporate facility consultant in-serviced the DON related to the appropriate functioning of the QAPI Committee and the purpose of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 26 During the 10/6/21 recertification survey the facility failed to accurately code the Minimum Data Set (MDS) for weight loss, anticoagulants, and indwelling catheter. During the 1/20/23 recertification and complaint survey the facility failed to accurately complete the Minimum Data Set (MDS) for discharge and anticoagulant (blood thinning medication). F 656 Based on observation, record review, resident and staff interviews, the facility failed to develop a comprehensive person-centered care plan for a resident that smoked for 1 of 1 resident (Resident #50) reviewed for supervision to prevent accidents. During the 1/20/23 recertification and complaint survey the facility failed to develop and implement a comprehensive individualized person-centered care plan. F 761 Based on observation, record review, and staff interview the facility failed to remove expired medications from the refrigerator for 2 of 2 med rooms. During the 10/6/21 recertification survey the facility failed to discard expired medications in medication carts, and narcotics in the narcotic lock box contained no expiration date in a medication cart. An interview was conducted on 05/01/24 at 4:10 PM with the Administrator. She stated the quality assurance (QA) committee met both monthly and quarterly. The committee members included the Social Worker, Activity Director, Therapy Manager, Admission Coordinator, Business Office Manager, Dietary Manager, Maintenance	F 867	committee to include identify issues and correct repeat deficiencies related F641 and F867. • As of 05/03/2024 after the corporate facility consultant in-serviced the DON the facility QAPI Committee will begin identifying other areas of quality concern through the quality improvement (QI) review process, for example: review of rounds tools, review of work orders, review of Point Click Care (PCC - electronic health record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, review of audits related to the plan of correction, and review of regional facility consultant recommendations. • The QAPI committee will meet at a minimum of monthly and the Executive QAPI committee will meet a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. • Corrective action has been taken for the identified concerns related to repeat deficiency. • The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. • The QAPI committee will continue to meet at a minimum of quarterly, and QAPI committee monthly with oversight by a corporate staff member. • The QAPI committee, including the medical director, will review quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 27 Manager, Director of Nursing, Assistant Director of Nursing, Administrator, and Medical Records Manager. She added that currently the QA committee was attempting to identify issues with nursing documentation, as well as laboratory results. The Administrator stated the last MDS nurse had to leave the position and the facility went for a period without an MDS coordinator, so she stepped in to cover this role. She elaborated that they now have a new MDS Coordinator. Regarding failure to develop/implement care planning, she stated that the MDS coordinator was also responsible for develop/implement care planning. The new MDS/Care Plan Coordinator did not have experience in either area (MDS, care planning), and she was currently being trained on the job.	F 867	compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The QAPI committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.	